FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033647

Facility Name: Snyder Village

Address: 1200 East Partridge (Number) Metamora (City) 61548 (Zip Code)

County: Woodford

Telephone Number: (309) 367-4300 **Fax #** (309) 367-2235

IDPA ID Number: 37-1194111001

Date of Initial License for Current Owners: 30-Jun-88

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (c) 3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Keith Swartzentruber **Telephone Number:** (309) 367-4300

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Keith Swartzentruber
(Title) Administrator

Paid Preparer
(Signed) _____ March 25, 2003 (Date)
(Print Name and Title) Robert Rein, Practitioner
(Firm Name & Address) Robert Rein, CPA, P.O. Box 201, Morton, Illinois 61550-0201
(Telephone) (309) 266-8178 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** ########

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	105	Skilled (SNF)	105	38,325	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	105	TOTALS	105	38,325	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,168	23,624	2,060	33,852	8
9	SNF/PED					9
10	ICF	969	2,150		3,119	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,137	25,774	2,060	36,971	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.47%

D. How many bed-hold days during this year were paid by Public Aid? 76 **(Do not include bed-hold days in Section B.)**

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] **NO** [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] **NO** [X]

I. On what date did you start providing long term care at this location?
Date started 06/30/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] **Date** 06/30/88 **NO** [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] **NO** [ ] **If YES, enter number of beds certified** 29 **and days of care provided** 2,060

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

		MODIFIED CASH*		CASH*	
ACCRUAL	X				

Is your fiscal year identical to your tax year? **YES** [X] **NO** [ ]

Tax Year: 12/31/02 **Fiscal Year:** 12/31/02

*** All facilities other than governmental must report on the accrual basis.**

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	263,445		22,710	286,155		286,155		286,155			1
2	Food Purchase		188,072		188,072		188,072	(52,197)	135,875			2
3	Housekeeping	165,952	19,154	785	185,891		185,891	(2,053)	183,838			3
4	Laundry	79,518	16,706		96,224		96,224		96,224			4
5	Heat and Other Utilities			103,414	103,414		103,414	(29,289)	74,125			5
6	Maintenance	101,480	18,919	26,859	147,258		147,258	(4,227)	143,031			6
7	Other (specify):*											7
8	**TOTAL General Services**	610,395	242,851	153,768	1,007,014		1,007,014	(87,766)	919,249			8
	B. Health Care and Programs											
9	Medical Director			1,725	1,725		1,725		1,725			9
10	Nursing and Medical Records	2,301,007	28,663	126,370	2,456,040		2,456,040	(16,513)	2,439,527			10
10a	Therapy	57,704	1,683	144,419	203,806		203,806		203,806			10a
11	Activities	111,512	5,972	355	117,839		117,839		117,839			11
12	Social Services	70,204	559	947	71,710		71,710	(4,267)	67,443			12
13	Nurse Aide Training	14,552	390	1,250	16,192		16,192		16,192			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,554,979	37,267	275,066	2,867,312		2,867,312	(20,780)	2,846,532			16
	C. General Administration											
17	Administrative	61,591			61,591		61,591		61,591			17
18	Directors Fees											18
19	Professional Services			34,409	34,409		34,409		34,409			19
20	Dues, Fees, Subscriptions & Promotions			52,809	52,809	1,116	53,925	(2,344)	51,581			20
21	Clerical & General Office Expenses	168,808	18,329	37,363	224,500	1,780	226,280	(92,689)	133,591			21
22	Employee Benefits & Payroll Taxes			750,594	750,594	(1,116)	749,478		749,478			22
23	Inservice Training & Education			2,220	2,220		2,220		2,220			23
24	Travel and Seminar			6,561	6,561	(2,977)	3,584		3,584			24
25	Other Admin. Staff Transportation					1,197	1,197		1,197			25
26	Insurance-Prop.Liab.Malpractice			41,944	41,944		41,944		41,944			26
27	Other (specify):*											27
28	**TOTAL General Administration**	230,399	18,329	925,900	1,174,628		1,174,628	(95,034)	1,079,594			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,395,773	298,447	1,354,734	5,048,954		5,048,954	(203,579)	4,845,375			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Snyder Village Health Center 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			212,646	212,646		212,646	488	213,134			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			123,448	123,448		123,448	(13,222)	110,226			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,105	9,105		9,105		9,105			35
36	Other (specify):*											36
37	**TOTAL Ownership**			345,199	345,199		345,199	(12,734)	332,465			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		178,281	4,085	182,366		182,366		182,366			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,487	57,487		57,487		57,487			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		178,281	61,572	239,853		239,853		239,853			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,395,773	476,728	1,761,505	5,634,006		5,634,006	(216,313)	5,417,693			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** ########

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(26,072)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	488	30.3		9
10	Interest and Other Investment Income	(13,222)	32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,344)	20.3		28
29	Other-Attach Schedule	(175,163)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (216,313)		$	30

OHF USE ONLY							
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (216,313)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
This work paper section is not applicable.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [ ] **YES** [X] **NO**

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This work paper section is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This work paper section is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Commerce Bank		X	Building	$ 12,758.00	Aug-87	$ 3,450,000	$ 1,609,481	Sep-26	5.07%	$ 88,584	1
2	CDAP Village Metamora		X	Building	4,340.00	Various	614,000	261,672	Various	3.00%	8,476	2
3	Commerce Bank		X	Bldg Construction	4,855.00	Feb-01	500,000	281,128	May-07	4.25%	18,662	3
4	Commerce Bank		X	Patient Transport Vehicle	562.00	Nov-02	29,900	29,009	Oct-07	4.25%	210	4
5	Woodford County		X	Bldg Construction	1,887.00	Dec-00	100,000	61,340	Nov-05	5.00%	3,543	5
	Working Capital											
6	Gift Annuity		X	Building	510.00	Various	84,000	57,190	Various	6.75%	3,973	6
7												7
8									Less: Interest Income		(13,222)	8
9	**TOTAL Facility Related**				$ 24,912.00		$ 4,777,900	$ 2,299,819			$ 110,226	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$ 4,777,900	$ 2,299,819			$ 110,226	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For _____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

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13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** **This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Snyder Village Health Center COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0033647

CONTACT PERSON REGARDING THIS REPORT Keith Swartzentruber

TELEPHONE (309) 367-4300 FAX #: (309) 367-2235

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. **Square Feet:** 36,870 **B. General Construction Type:** **Exterior** Brick **Frame** Wood & Steel **Number of Stories** One

C. **Does the Operating Entity?** [X] **(a) Own the Facility** [ ] **(b) Rent from a Related Organization.** [ ] **(c) Rent from Completely Unrelated Organization.**

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. **Does the Operating Entity?** [X] **(a) Own the Equipment** [ ] **(b) Rent equipment from a Related Organization.** [X] **(c) Rent equipment from Completely Unrelated Organization.**

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. **List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)**

Snyder Village Retirement Community Apartments - 41 Apartments @ 38,793 Ft2

Snyder Village Retirement Community Cottages - 118 Cottages @ 283,200 Ft2

F. **Does this cost report reflect any organization or pre-operating costs which are being amortized?** [ ] **YES** [X] **NO**
If so, please complete the following:

1. Total Amount Incurred: **2. Number of Years Over Which it is Being Amortized:**

3. Current Period Amortization: **4. Dates Incurred:**

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	155,422	1987	$ 43,000	1
2	Nursing Home		2001	1,300	2
3	**TOTALS**	155,422		$ 44,300	3

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	61		1988	1988	$ 1,929,231	$ 42,872	45	$ 42,872	$	$ 621,642	4
5			1992	1992	127,495	2,833	45	2,833		29,985	5
6			1992	1992	33,830	1,353	25	1,353		13,757	6
7	18		1994	1994	600,872	13,353	45	13,353		117,949	7
8	26		1994	1994	1,256,597	27,924	45	27,924		225,722	8
	Improvement Type**										
9	Fire Control System			1989	5,152	258	20	258		3,414	9
10	Century Tub			1989	7,694		10			7,694	10
11	Asphalt			1990	1,820	91	20	91		1,138	11
12	Alzheimer's Courtyard			1990	3,644		10			3,644	12
13	Heat Exchanger			1990	1,650		10			1,650	13
14	Tub			1991	1,465		10			1,465	14
15	Door Locks			1991	1,400	70	20	70		776	15
16	Door Locks			1992	1,200	60	20	60		645	16
17	Patio			1992	1,219	51	10	51		1,219	17
18	Entrance Light			1993	619	62	10	62		594	18
19	Land Improvement			1994	25,546	1,277	20	1,277		10,324	19
20	Services Windows			1995	201,662	4,481	45	4,481		33,107	20
21	Landscaping			1995	13,848	692	20	692		3,364	21
22	Canopy			1995	1,102	55	20	55		390	22
23	Electrical Maintenance			1995	595	40	15	40		291	23
24	Door Locks			1995	505	34	15	34		250	24
25	Front Canopy			1996	44,945	999	45	999		5,477	25
26	Tower			1996	7,360	368	20	368		2,453	26
27	Door Open			1996	3,344	334	10	334		2,117	27
28	Landscaping			1997	1,500	75	20	75		413	28
29	Front Door Wiring			1997	1,396	70	20	70		407	29
30	Kelly Glass			1998	3,527	176	20	176		881	30
31	MTCO Phone System			1998	18,914	757	25	757		2,279	31
32	Carpet			1998	15,719	1,572	10	1,572		6,550	32
33	Heater			1999	1,784	178	10	178		668	33
34	Security Camera			1999	2,510	167	15	167		669	34
35	Motion Detector			1999	790		10	79	79	316	35
36	Shelving			1999	673		10	67		268	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Automatic Door Open	2000	$ 5,449	$	15	$ 363	$ 363	$ 908	37
38	Blacktop	2000	21,736	1,087	20	1,087		2,264	38
39	Sunroom	2000	86,410	1,920	45	1,920		4,797	39
40	Generator	2000	36,206	1,810	20	1,810		4,451	40
41	Time Clock	2000	7,789	1,558	5	1,558		4,414	41
42	Motion Detector	2000	5,714	571	10	571		1,523	42
43	Nursing Office Addition	2001	751,810	16,707	45	16,707		25,151	43
44	Sunroom	2001	11,315	1,132	10	1,132		2,264	44
45	Tower	2001	5,640	564	10	564		893	45
46	Door	2001	2,545	255	10	255		297	46
47	Carpet	2001	3,529	353	10	353		412	47
48	Landscaping	2001	4,943	247	20	247		432	48
49	Blacktop	2001	12,054	603	20	603		704	49
50	Roof	2002	36,779	1,430	15	1,431	1	1,431	50
51	Hall 2 Room Alert	2002	5,015	919	5	915	(4)	915	51
52					-				52
53					-				53
54					-				54
55					-				55
56					-				56
57					-				57
58					-				58
59					-				59
60					-				60
61					-				61
62					-				62
63					-				63
64					-				64
65					-				65
66					-				66
67					-				67
68					-				68
69					-				69
70	**TOTAL (lines 4 thru 69)**		$ 5,316,542	$ 129,358		$ 129,864	$ 439	$ 1,152,374	70

****Improvement type must be detailed in order for the cost report to be considered complete**

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 433,866	$ 55,444	$ 55,444	$	various	$ 311,064	71
72	Current Year Purchases	48,022	9,119	9,119		various	9,119	72
73	Fully Depreciated Assets	306,944				various	306,944	73
74								74
75	TOTALS	$ 788,832	$ 64,563	$ 64,563	$		$ 627,127	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1985 Ford Van	01/01/91	$ 3,130	$	$	$	3	$ 3,130	76
77	Resident Transportation	1994 Van	01/01/94	47,025	4,703	4,703		10	38,796	77
78	Resident Transportation	1996 Van	01/01/96	51,573	5,157	5,157		10	31,373	78
79	Resident Care	1992 Truck	01/01/97	16,367	1,091	1,091		10	16,367	79
80	TOTALS			$ 170,254	$ 18,725	$ 18,707	$ (18)		$ 108,123	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,319,928	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 212,646	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 213,134	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 488	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,887,624	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 3,190	92
93			93
94			94
95		$ 3,190	95

* **Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.**

** **This must agree with Schedule V line 30, column 8.**

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$						71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$	$	$	$		$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance Use	1999 Tate Truck	01/01/99	$ 6,850	$ 1,370	$ 1,370	$	5	$ 5,137	76
77	Maintenance Use	1999 Grimm Truck	01/01/99	15,409	3,082	3,082		5	10,016	77
78	Patient Transport	2000 Ford Van	09/01/02	29,900	3,322	3,304	(18)	3	3,304	78
79										79
80	TOTALS			$ 52,159	$ 7,774	$ 7,756	$ (18)		$ 18,457	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		$	95

* **Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.**

** **This must agree with Schedule V line 30, column 8.**

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 9,105 Description: Postage Meter ($764) and Copier ($8,341)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	x
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	x
IN OTHER FACILITY	
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			390		390
3	Classroom Wages	(a)		5,466		5,466
4	Clinical Wages	(b)		2,733		2,733
5	In-House Trainer Wages	(c)		6,354		6,354
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			1,250		1,250
9	TOTALS		$	$ 16,192	$	$ 16,192
10	SUM OF line 9, col. 1 and 2	(e)	$ 16,192			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	10

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	$	195	$ 10,208	$	195	$ 10,208	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		112	6,863		112	6,863	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		302	16,718		302	16,718	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts				61,864		61,864	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Medical Supplies	39.2					116,418		116,418	13
14	TOTAL			$	609	$ 33,789	$ 178,281	609	$ 212,070	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed or Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 263,751	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance **(20,000)**)	864,010		3
4	Supply Inventory (priced at FIFO)	24,699		4
5	Short-Term Investments	456,455		5
6	Prepaid Insurance	7,743		6
7	Other Prepaid Expenses	2,976		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,619,634	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	31,649		12
13	Land	44,300		13
14	Buildings, at Historical Cost	5,155,936		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,115,814		16
17	Accumulated Depreciation (book methods)	(1,894,346)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	115,616		22
23	Other(specify): Construction in Progress	3,190		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,572,159	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,191,793	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (59,928)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(217,586)		30
31	Accrued Taxes Payable (excluding real estate taxes)	(51,117)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee Benefits Payable	(125,804)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (454,435)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	(2,299,819)		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (2,299,819)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (2,754,254)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,437,539)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (6,191,793)	$	48

***(See instructions.)**

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** ###### **Ending:** 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	**$** 3,297,034	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,297,034	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	140,501	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	4	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 140,505	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,437,539	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ (5,294,774)	1
2	Discounts and Allowances for all Levels	535,298	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ (4,759,476)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(358,170)	6
7	Oxygen	(76,817)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ (434,987)	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	(6,927)	11
12	Gift and Coffee Shop	(9,841)	12
13	Barber and Beauty Care	(3,735)	13
14	Non-Patient Meals	(26,072)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(144,177)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	(5,321)	20
21	Other Medical Services	(138,013)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (334,086)	23
	D. Non-Operating Revenue		
24	Contributions	(98,264)	24
25	Interest and Other Investment Income***	(13,222)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (111,486)	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Non-Care Revenues	(120,069)	28
28a	Other Income	(14,403)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (134,472)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ (5,774,507)	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,007,014	31
32	Health Care	2,867,312	32
33	General Administration	1,174,628	33
	B. Capital Expense		
34	Ownership	345,199	34
	C. Ancillary Expense		
35	Special Cost Centers	182,366	35
36	Provider Participation Fee	57,487	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,634,006	40
41	**Income before Income Taxes (line 30 minus line 40)****	(140,501)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (140,501)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Yes **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,867	2,080	$ 43,151	$ 20.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	32,393	37,508	735,809	19.62	3
4	Licensed Practical Nurses	15,989	17,192	253,835	14.76	4
5	Nurse Aides & Orderlies	105,193	113,462	1,222,868	10.78	5
6	Nurse Aide Trainees	796	796	8,198	10.30	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,774	5,295	57,704	10.90	8
9	Activity Director	1,881	2,080	22,178	10.66	9
10	Activity Assistants	8,397	9,087	89,333	9.83	10
11	Social Service Workers	5,577	6,235	70,204	11.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,511	30,850	263,445	8.54	15
16	Dishwashers					16
17	Maintenance Workers	7,321	8,466	101,480	11.99	17
18	Housekeepers	14,697	16,838	165,952	9.86	18
19	Laundry	7,727	9,144	79,518	8.70	19
20	Administrator	1,825	2,080	61,591	29.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,876	2,080	31,371	15.08	23
24	Clerical	8,480	10,480	114,222	10.90	24
25	Vocational Instruction	324	324	6,354	19.61	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Ward Clerk	3,897	4,191	45,343	10.82	33
34	TOTAL (lines 1 - 33)	249,523	278,187	$ 3,372,558 *	$ 12.12	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	153	$ 7,923	1.3	35
36	Medical Director	12	1,725	9.3	36
37	Medical Records Consultant	14	360	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	900	10.3	39
40	Physical Therapy Consultant	161	8,892	10a.3	40
41	Occupational Therapy Consultant	78	4,096	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	6	250	11.3	44
45	Social Service Consultant	15	880	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	451	$ 25,026		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	470	$ 15,289	10.3	50
51	Licensed Practical Nurses	745	21,221	10.3	51
52	Nurse Aides	4,942	86,482	10.3	52
53	TOTAL (lines 50 - 52)	6,157	$ 122,993		53

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Keith Swartzentruber	Administrator	-0-	61,591
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,591

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heinold Banwart LTD	Accounting	$ 12,600
Altschuler Melvoin & Glasser LLP	Accounting	8,000
American Express Tax & Business Svc	Accounting	400
Davis & Campbell LLC	Legal	4,246
Lueders, Robertson, Konzen	Legal	195
Pathlinks	Computer	8,968
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		**$** 34,409

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,421
Unemployment Compensation Insurance	
FICA Taxes	247,637
Employee Health Insurance	281,416
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Pension Plan	97,755
Employee Life/Disability	6,059
Employee Flex Time	13,187
Hep B & Employee Physicals	3,482
Employee Appreciation	14,846
Other Benefits	676
TOTAL (agree to Schedule V, line 22, col.8)	$ 749,478

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		**$**

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	29,979
Health Care Worker Background Check	1,116
(Indicate # of checks performed 93 **)**	
Life Services Network of IL	5,000
Wellspring Innovative Solutions	17,255
Dues & Licenses	529
Subscriptions	47
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(2,344)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 51,581

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,448
Seminar Expense	2,136
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,584

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** #######

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Carpentry	May 2001	$ 1,244		$	$	$ 124	$ 249	$ 249	$ 249	$ 249	$ 124	$
2													
3													
4													
5													
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19													
20	TOTALS		$ 1,244		$	$	$ 124	$ 249	$ 249	$ 249	$ 249	$ 124	$

Facility Name & ID Number Snyder Village Health Center # 0033647 **Report Period Beginning:** 1/1/2002 **Ending:** #######

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of IL 5,000

(3) Did the nursing home make political contributions or payments to a politica
action organization? No If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 4.5

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ 17,001 Line 10.2

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. No

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ 57,487
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? Yes OP Therapy For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ Has any meal income been offset against
related costs? Yes Indicate the amount. $ 26,072

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? No If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Heinold Banwart LTD The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? Yes If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees